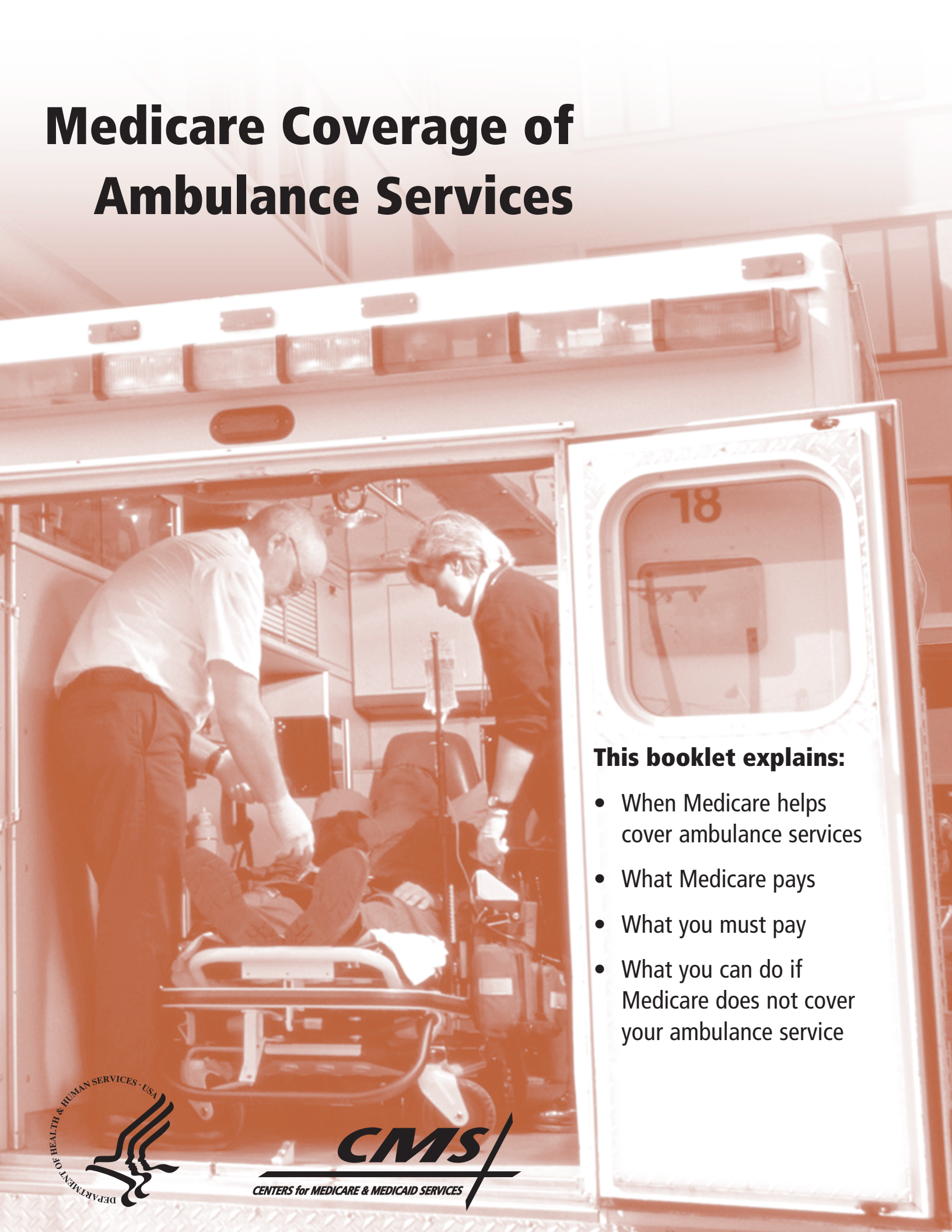
Medicare Coverage of Ambulance Services



This booklet explains:

- When Medicare helps cover ambulance services
- What Medicare pays
- What you must pay
- What you can do if Medicare does not cover your ambulance service

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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CENTERS for MEDICARE & MEDICAID SERVICES

Table of Contents

The *Medicare Coverage of Ambulance Services* booklet is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Introduction

The information in this booklet is for people who are in the Original Medicare Plan.

This booklet explains Medicare coverage of ambulance services in the Original Medicare Plan. The Original Medicare Plan is a "fee-for-service" plan. This means you are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care.

If you are not in the Original Medicare Plan, read your plan materials for ambulance coverage.

If you are in a Medicare + Choice Plan, you may have different rules, but your plan must give you at least the same coverage as the Original Medicare Plan. Your costs, rights, protections, and/or choices of where you get your care may be different if you are in one of these plans. You may also get extra benefits. Read your plan materials or call your benefits administrator for more information.

Medicare covers some ambulance and other health care services.

It is important to know what health care services Medicare helps to cover. You get all your regular Medicare covered services under Part A and Part B. To learn more about Medicare, look at the Medicare Basics information on the next two pages. You can also look at your copy of the *Medicare & You* handbook (CMS Pub. No. 10050), which is mailed each fall to people with Medicare. You can order a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also read or print a copy of this handbook at www.medicare.gov on the web. Select "Publications."

Words in brown are defined on pages 12–13.

Important: The information in this booklet was correct when it was printed. Changes may occur after printing. For the most up-to-date version, look at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). A Customer Service Representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

Medicare Basics

What is Medicare?

Medicare is a health insurance program for:

- People age 65 or older.
- Some people with disabilities under age 65.
- Many people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has Two Parts:

Part A, Hospital Insurance

Most people do not have to pay for Part A. This is because they or a spouse paid Medicare taxes while they were working. Medicare Part A helps cover your inpatient care in hospitals*, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care. You must meet certain conditions.

Part B, Medical Insurance

Most people pay monthly for Part B. Medicare Part B helps cover your ambulance services, doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

*Medicare Part A covers your ambulance service once you are admitted to a hospital and you need to be transported to another hospital or site as part of your care.

Words in brown are defined on pages 12–13.

Medicare Basics

Medicare Health Plans

Your health plan choices include:

The Original Medicare Plan - available nationwide.

OR

Medicare + Choice Plans, including:

- Medicare Managed Care Plans.
- Medicare Private Fee-for-Service Plans.
- Medicare Preferred Provider Organization Plans.

These choices are available in many areas of the country. The way you get your Medicare health care affects many things, like cost, doctor choice, benefits, convenience, and quality.

If you join a Medicare + Choice Plan:

- You are still in the Medicare program.
- You must have Medicare Part A and Part B, and continue to pay the monthly Medicare Part B premium ($66.60 in 2004). If you are already in a Medicare Managed Care Plan and have only Part B, you may stay in your plan.
- You still get all your regular Medicare-covered services. You may be able to get extra benefits like coverage for prescription drugs or additional days in the hospital.
- You have Medicare rights to protect you (see pages 9–10).

For help comparing your health plan choices, use the "Medicare Personal Plan Finder," available at www.medicare.gov on the web. You can also call 1-800-MEDICARE (1-800-633-4227), and select option "0." A Customer Service Representative will help you compare health plan choices. You will get your Medicare Personal Plan Finder results in the mail within three weeks.

Words in brown are defined on pages 12–13.

Medicare Coverage of Ambulance Services

Medicare Part B covers ambulance services to or from a hospital or skilled nursing facility only when other transportation would be dangerous to your health. In addition, you can be transported from your home or a medical facility to get care for a health condition that requires you to be transported only by ambulance.

Emergency ambulance transportation

Emergency ambulance transportation is provided after you have had a sudden medical emergency, when your health is in serious danger, and when every second counts to prevent your health from getting worse. Some examples of when emergency ambulance transportation may be considered by the Medicare Carrier (the company that handles Part B bills for Medicare) may include when you:

- Are in severe pain, are bleeding, are in shock
- Are unconscious
- Need to be restrained to keep you from hurting yourself or others
- Need oxygen or other skilled medical treatment during transportation

These are only examples of when Medicare would cover your ambulance trip. Coverage would depend on the seriousness of your medical condition and whether you could have been transported by other means.

Medicare will only cover ambulance services to the nearest appropriate facility that is able to give you the care you need. If you choose to be transported to a facility farther away, Medicare's payment will be based on the charge to the closest facility. If no local facilities are able to give you the care you need, Medicare will help pay for transportation to a facility outside of your local area.

Medicare will pay for emergency ambulance transportation in an airplane or helicopter if your health condition requires immediate and rapid ambulance transportation that cannot be provided by ground transportation.

Words in brown are defined on pages 12–13.

Medicare Coverage of Ambulance Services

Nonemergency ambulance transportation

Nonemergency ambulance transportation is provided when you need transportation to diagnose or treat your health condition and you can't be transported another way. You must have orders from your doctor or health care provider.

Medicare covers some nonemergency ambulance transportation. This service is limited. Medicare may cover your nonemergency trip if you are confined to your bed and you have a statement from your doctor saying that ambulance transportation is necessary because of your medical condition. Even if you are not confined to your bed, Medicare may still cover your nonemergency ambulance trip if you have a statement from your doctor.

If the ambulance company believes that Medicare will not pay for your nonemergency ambulance service, they might ask you to sign an Advance Beneficiary Notice (ABN).

See pages 9–10 on appeal rights.

You will be asked to choose between two options by marking a box and signing the ABN. If you choose the first option and sign, you are agreeing to pay the full cost for the trip if Medicare does not pay. If you choose the second option and sign, you are agreeing to not be transported. You cannot appeal if you choose the second option.

If you refuse to sign the ABN, the ambulance company can decide whether to take you by ambulance. If the ambulance company decides to transport you after your refusal to sign, you are responsible for paying the cost of the trip if Medicare does not.

You will not be asked to sign an ABN in an emergency situation (see page 5).

Words in brown are defined on pages 12–13.

Medicare Coverage of Ambulance Services

What does Medicare pay?

If Medicare covers your ambulance trip, Medicare will pay 80% of the Medicare-approved amount after you have met the yearly Part B deductible ($100 in 2004). Medicare's payment will be different if you get services from a hospital-based ambulance company.

What do I pay?

If Medicare covers your ambulance trip, you pay 20% of the Medicare-approved amount, after you have met the yearly Part B deductible ($100 in 2004).

The ambulance company cannot charge you more than 20% of the Medicare-approved amount. All ambulance companies must accept Medicare assignment. This means that the ambulance company must accept the Medicare-approved amount as payment in full.

How do I know if Medicare won't pay for my ambulance service?

You will get a Medicare Summary Notice (MSN), from the Medicare Carrier. The notice will tell you why Medicare did not pay for your ambulance trip. If Medicare didn't pay, you may find one of the following statements on your MSN*:

- Payment for ambulance transportation is allowed only to the closest appropriate facility that can provide the care you need.
- Transportation to a facility to be closer to your home or family is not covered.
- The information provided does not support the need for an ambulance.
- Payment for ambulance services does not include mileage when you were not in the ambulance.

Words in brown are defined on pages 12–13.

*These are only examples of what you may see on your MSN. You may see a different statement depending on your situation.

Call your Medicare Carrier, if you have questions about your MSN. The name and number of your Medicare Carrier is listed on the top of the MSN.


Emergency
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861 DJC

Medicare Rights and Protections

What can I do if Medicare doesn't pay for an ambulance trip I think they should have covered?

You have the right to file an appeal.

If you have Medicare, you have certain guaranteed rights to help protect you. One of these rights is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services.

If Medicare decides it won't cover your ambulance trip, you have a right to appeal. To file an appeal, look on the back of your Medicare Summary Notice (MSN). It will tell you why your bill was not paid, how long you have to file an appeal, and what appeal steps you can take. If you decide to file an appeal, ask your doctor or provider for any information that might help your case. You should keep a copy of everything you send to Medicare as part of your appeal. If you need help filing an appeal, call 1-800-MEDICARE (1-800-633-4227) to get the number for the State Health Insurance Assistance Program in your state.

You may find paperwork problems that can be fixed without filing an appeal.

Before you decide to appeal, you or someone you trust should carefully review your MSN and any other paperwork about your ambulance bill. You can also call your Medicare Carrier, the company that pays Medicare Part B bills, to get a more detailed explanation of why Medicare denied payment.

While reviewing your MSN and other paperwork, you may find that Medicare has denied your claim because:

1) **The ambulance company did not fully document why you needed ambulance transportation.**

   If this happens, contact the doctor who treated you or the discharge social worker at the hospital to get more information about your need for transportation. You can send this information to the Medicare Carrier.

Words in brown are defined on pages 12–13.

2) **The ambulance company did not file the proper paperwork.**

If this happens, you can ask the ambulance company to refile your claim form. Do not pay the bill until the ambulance company has done this. If the ambulance company will not refile your claim, contact your Medicare Carrier. Your Medicare Carrier will contact the ambulance company on your behalf to make them aware of their responsibility for filing a Medicare claim. If refiling your claim does not result in payment, the next step is to appeal.

What other Medicare rights and protections do I have?

In addition to your appeal rights, you also have the right to:

- Be treated with dignity and respect at all times.
- Be protected from discrimination.
- Get information about Medicare that you can understand to help you make health care decisions.
- Have your questions about the Medicare program answered.
- Get emergency care when and where you need it.
- Learn about all of your treatment choices in clear language that you can understand.
- File a complaint.
- Have your personal information that Medicare collects about you kept private.
- Talk with your health care provider in private and have your personal health care information kept private.

Words in brown are defined on pages 12–13.

There is a new patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used by your health care provider or health plan.

For more detailed information about your Medicare rights and protections, you can get a free copy of the booklet *Your Medicare Rights and Protections* (CMS Pub. No. 10112). To get a free copy, see page 11.

Getting More Information

To get more information about Medicare and related topics:

Call 1-800-MEDICARE (1-800-633-4227)

for answers and information 24 hours a day, including weekends.

OR

Visit our website, www.medicare.gov

Free Booklets

Medicare tries to give you information to help you make good health care decisions. You can look at or order free booklets from Medicare to learn more about the topics that are of interest to you. We are always adding new booklets with detailed information about important subjects.

How do I get these booklets?

1. Look at www.medicare.gov on the web and select "Publications." You can read, print, or order these booklets. This is the fastest way to get a copy.

2. Call 1-800-MEDICARE (1-800-633-4227), and select option "4" to order a free copy of the booklet you want. TTY users should call 1-877-486-2048. You will get your copy within three weeks.

3. Put your name on the web mailing list to get an email message every time a new booklet is available. To sign up, go to www.medicare.gov and select "Subscribe to Our Mailing List" at the bottom of the page. Then, select the topic "Publications," type your email address in the box at the bottom, and select "Subscribe."

Many booklets are available in English, Spanish, Audiotape (English and Spanish), Braille, and Large Print (English and Spanish). Some booklets are also available in Chinese.

Note: Some booklets may not be available in print, but all will be available at www.medicare.gov on the web.

Words to Know

Advance Beneficiary Notice (ABN) - A notice that a doctor or supplier should give a Medicare beneficiary when furnishing an item or service for which Medicare is expected to deny payment.

If you do not get an ABN before you get the service from your doctor or supplier, and Medicare does not pay for it, then you probably do not have to pay for it. If the doctor or supplier does give you an ABN that you sign before you get the service, and Medicare does not pay for it, then you will have to pay your doctor or supplier for it. ABN's only apply if you are in the Original Medicare Plan. They do not apply if you are in a Medicare Managed Care Plan or Private Fee-for-Service Plan.

Appeal - An appeal is a special kind of complaint you make if you disagree with any decision about your health care services. For example, you could file an appeal if Medicare doesn't pay or doesn't pay enough for a service you got, or an item or service you think you should get. This complaint is made to your Medicare + Choice Plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint.

Assignment - In the Original Medicare Plan, this means a doctor or supplier agrees to accept Medicare's fee as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor or supplier accepts assignment. You still pay your share of the cost of the doctor's visit.

Critical Access Hospital - A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Deductible - The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

Medicare-Approved Amount - The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medicare Carrier - A private company that contracts with Medicare to pay Part B bills.

Medicare Managed Care Plan - These are health care choices (like HMOs) in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare + Choice Plan - A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Words To Know

Medicare Preferred Provider Organization Plan - A Medicare + Choice Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Private Fee-for-Service Plan - A private insurance plan that accepts people with Medicare. You may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you will pay for the services you get. You may pay more for Medicare-covered benefits or you may have extra benefits the Original Medicare Plan does not cover.

Medicare Summary Notice (MSN) - A notice you get after the doctor or provider files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Original Medicare Plan - A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (hospital insurance) and Part B (medical insurance).

Premium - The periodic payment you make to Medicare, an insurance company, or a health care plan for health care coverage.

Skilled Nursing Facility - A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

State Health Insurance Assistance Program - A state program that gets money from the Federal Government to give free health insurance counseling and assistance to people with Medicare.

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To get this booklet in English or Spanish, call 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048.

Para obtener este folleto español, llame gratis al 1-800-MEDICARE (1-800-633-4227).
TTY 1-877-486-2048 para personas con impedimentos auditivos o del lenguaje oral.